TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR MEDICAL CENTER

Respondent Name
EMPLOYERS MUTUAL CASUALTY COMPANY

MFDR Tracking Number
M4-18-0704-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached you will find the UB-04, explanation of benefits (claim denied due to lack of authorization), medical documentation, itemized billing and insurance verification information with authorization number . . ."

Amount in Dispute: $10,314.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request for preauthorization did not include procedure codes 63042 and 63044."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Dispute Amount	Amount Due
August 22, 2017	Outpatient Hospital Services	$10,314.06	$10,314.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
     With additional remittance advice: PROCEDURES 63042 & 63044 WERE NOT PREAUTHORIZED.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:

   197 – PRECERTIFICATION/AUTHORIZATION ABSENT

   With additional remittance advice: PROCEDURES 63042 & 63044 WERE NOT PREAUTHORIZED.

   The respondent asserts, "The provider's . . . request for preauthorization requested specific procedure codes. Specifically, they requested procedure codes 63047 and 63048. The request for preauthorization did not include procedure codes 63042 and 63044."

   CPT code 63047 is defined as laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s]), single vertebral segment; lumbar. CPT code 63048 denotes the same procedure performed per each additional segment.

   CPT code 63042 is defined as laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar. CPT code 63048 denotes the same procedure performed per each additional segment.

   The division notes the term "laminectomy" indicates complete removal of the lamina, whereas "laminotomy" indicates only partial removal of the lamina. Both procedures are spinal decompression surgeries. Both services are assigned to APC 5114, and both receive the same reimbursement amount under division fee guidelines.

   Regarding the carrier's denial code, the submitted documentation supports precertification/authorization was *not* absent. The respondent provided a copy of the letter authorizing surgery. Review of the submitted Notification of Certification letter finds the authorization does not reference any specific procedure codes, but rather describes the approved service(s) as "Decompression Revision Surgery at L4-5 and L5-S1."

   Review of the disputed service finds that the service is decompression revision surgery at L4-5 and L5-S1.

   Rule §134.600(l) requires that the insurance carrier shall not withdraw a preauthorization approval once issued. Paragraph §134.600(l)(1) further requires that the carrier's approval shall include: "the specific health care."

   The respondent argues that the request for preauthorization:

   > did not include procedure codes 63042 and 63044. Accordingly, there was no request for preauthorization of those services and since there was no request for preauthorization of them, the URA did not make a determination either as an approval nor an adverse determination since there was no request.

   Although Rule §134.600(f)(2) requires that the request for preauthorization shall include the: "specific health care listed in subsection (p) or (q) . . ." Rule §134.600(p) does not, however, list any specific procedure codes with regard to preauthorization of spinal surgeries, hospital admissions or outpatient surgical services as enumerated in that subsection. Accordingly, the respondent has not supported that the provider was required to list any specific procedure codes on the authorization request.

   According to the carrier's submitted utilization review and authorization documentation, the requested service(s) were "Decompression Revision Surgery at L4-5 and L5-S1." The requested services section does not mention any specific CPT codes. The document labeled "E-mail Notification" lists the services reviewed by Utilization Review as "Decompression Revision Surgery at L4-5 and L5-S1." This same document states under "ADDITIONAL COMMENTS:" that "UR Update Call Prov/Fac . . . on 07/05/17 . . . Made Contact; verified request, 1 day LOS and the procedure itself only."

   Furthermore, per Rule §134.600(l)(1), preauthorization approvals shall include "the specific health care." The specific health care listed on the Notification of Certification as "reviewed" and "determined to be medically necessary" was "Decompression Revision Surgery at L4-5 and L5-S1." The carrier's approval neither limits the authorization to any particular CPT codes nor even mentions any specific procedure codes.

The carrier approved the specific health care using a description of the services—without reference to procedure codes. Moreover, it did so after the UR agent called and verified the request with the health care provider by telephone conversation. Despite the respondent's argument to the contrary, it does not follow, and the respondent has failed to support, that the provider's authorization request was somehow deficient for similarly omitting reference to any particular CPT codes.

Documentation supports the provider requested and obtained authorization prior to performing services. Review of the submitted information finds the disputed services meet the description of the specific health care authorized in the carrier's Notification of Certification and approval of the preauthorization request, pursuant to Rule §134.600. The provider performed the services described in the preauthorization approval. The carrier's denial reasons are thus not supported. Consequently, per Rule §134.600(c), the insurance carrier is liable for the reasonable and necessary medical costs relating to the disputed health care. The services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting records. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 63042 has status indicator J1, denoting packaged services paid at a comprehensive rate. All services on the bill are packaged with this primary "J1" procedure. This surgery is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, which is multiplied by 60% for an unadjusted labor-related amount of $3,132.94, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $3,068.40. The non-labor related portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,157.03. The Medicare facility specific amount of $5,157.03 is multiplied by 200% for a MAR of $10,314.06.

3. Total recommended payment for the disputed services is $10,314.06. The amount previously paid by the insurance carrier is $0.00, leaving an amount due to the requestor of $10,314.06. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $10,314.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $10,314.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.